

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PUBLIC HEALTH DENTAL DISEASE PREVENTION PROGRAM
Request for Operation as Defined in MCL 333.16625 (2005 PA 161)**

AGENCY/ENTITY _____

CONTACT PERSON _____

ADDRESS _____

City _____ Zip Code _____ FAX NUMBER _____

TELEPHONE NUMBER _____ E-MAIL ADDRESS _____

AGENCY/ENTITY DESIGNATION: ☐ Public Health ☐ School
☐ Nursing Care Facility ☐ Other: _____
☐ Non-Profit Entity **Non-Profit Tax #:** _____

(Required if Non-Profit)

NEW PROGRAM ☐

RENEWAL ☐

Complete this section if a Public Health Agency: (all participating dentists and dental hygienists must hold current MI licenses)

Dental Director Name: _____

Michigan D.D.S./R.D.H. License Number of Staff: D.D.S.* _____ R.D.H.* _____

*You are required to notify
the Oral Health Program
of current staff license numbers

Days/Hours of Operation: _____

Dental Clinic Locations: _____

Complete this section for other than a Public Health Agency:

R.D.H. Name: _____ MI R.D.H. License # _____

Address: _____ Phone # _____

E-mail address: _____ Fax # _____

(use separate paper to include information for all R.D.H.s, if applicable)

Supervising D.D.S. Name: _____ MI D.D.S. License # _____

Address: _____ Phone # _____

E-mail address: _____ Fax # _____

Supervision circumstance: You must satisfy 1 or more of the following:

- ☐ Continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed dentist.
- ☐ The availability of a licensed dentist on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual's functions.
- ☐ The provision by the licensed supervising health professional of predetermined procedures and drug protocol.

Describe the clinical setting in which the service is to be provided: (check all that apply)

☐ Public Health Clinic ☐ Public Health Mobile Clinic ☐ Mobile Dental Clinic
☐ Nursing Facility Setting ☐ School-based/school-linked program

Other: Please describe: _____

Describe how the population served is a dentally underserved population*:

- ☐ Public Health Agency ☐ Nursing home residents that do not have a dentist of record
☐ Early Head Start ☐ Head Start
☐ School with 50% of the student population of that school or school entity is participating in Federal or State free and reduced meal programs; or b) rural school districts having a median income that is at or below 235% of the poverty line. Students treated should not have an assigned dentist.
☐ Migrant Farm Workers ☐ Native American Reservation
☐ Other (please explain) _____

Services to be provided: (check all that apply)

- ☐ Screening ☐ Preventive (Check all that apply)
☐ Radiographs ☐ Prophylaxis ☐ Oral Health Education
☐ Other Services: _____ ☐ Fluoride Varnish ☐ Topical Fluoride
_____ ☐ Pit and Fissure Sealant

WRITTEN DOCUMENTS:

Protocols: All of the following must be included in the program's written protocols submitted with this form.

- ☐ Patient Registration/Application Form ☐ Health History Review Form
☐ HIPAA Privacy Notice ☐ Infection Control Procedures
☐ Referral Procedures ☐ Parent Permission Form (if in a school setting)
☐ Supervision Protocol by a Dentist
☐ If sealants are performed, provide the evaluation measures that will be taken to ensure long-term retention of the sealants

Contracts:

- ☐ Contracts: Attach the following contracts, as appropriate.
☐ Agency/Entity: Attach contract with dentist or dental hygienist providing services
☐ R.D.H.: Attach contract with dentist that defines supervision

Please Note: Please initial the box next to the statement denoting that the statement has been read.

- ☐ Dental professionals are encouraged to have current continuing education in geriatrics (for nursing facility settings) and behavioral management and sealant placement courses for school settings.
☐ A hygienist can only administer anesthesia and nitrous oxide analgesia or perform soft tissue curettage under the direct supervision of a dentist.
☐ PA 161 will be monitored for Quality Assurance. The Oral Health Program may conduct record audits, review treatment records and request other quality assurance data such as sealant retention data.
☐ The Agency/Entity, Public Health Agency or Non-Profit. is responsible for notifying the MDCH/Oral Health Program of any information changes within 30 days of the change. PA 161 must be renewed every 2 years.
☐ If a patient resides in a nursing care facility, a physicians order for dental services is required for Medicaid beneficiaries. The order cannot be a standing order.
☐ Persons contracting with, employed by or providing services to schools and nursing homes must by law have a background check.

Signature of Dental Director of Public Health Agency

Date:

Printed Name of Contract Dental Hygienist

Signature of Contract Dental Hygienist

Date:

Printed Name of Supervising Dentist for Contract Hygienist

Signature of Supervising Dentist of Contract Hygienist

Date

PLEASE SEND COMPLETED FORM AND COPY OF WRITTEN PROGRAM PLAN, PROCOTOLS AND APPLICABLE CONTRACTS TO: Michigan Department of Community Health, Division of Family & Community Health, Oral Health Program, Washington Square Building, 109 W. Michigan, 4th Floor, Lansing, MI 48913 (For more information: Contact Dr. Sheila Semler, 517-335-8388, FAX: 517-335-8294, semlers@michigan.gov)

____ Approved ____ Not Approved

Janet Olszewski, Director

Date

The Department of Community Health is an equal opportunity employer, services, and programs provider.